SERFF Tracking Number:	*BNLA-127050943*	*State:*	*Arkansas*
Filing Company:	*Colonial Penn Life Insurance Company*	*State Tracking Number:*	*48231*
Company Tracking Number:	*CPL-28300B*		
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.012 Multi-Plan 2010*
Product Name:	*Revised CPL Med Supp Application*		
Project Name/Number:	*Revised CPL Med Supp Application/CPL-28300B*		

Filing at a Glance

Company: Colonial Penn Life Insurance Company

Product Name: Revised CPL Med Supp Application	SERFF Tr Num: BNLA-127050943	State: Arkansas
TOI: MS08I Individual Medicare Supplement - Standard Plans 2010	SERFF Status: Closed-Filed-Closed	State Tr Num: 48231
Sub-TOI: MS08I.012 Multi-Plan 2010	Co Tr Num: CPL-28300B	State Status: Filed-Closed
Filing Type: Form		Reviewer(s): Stephanie Fowler
	Authors: Thomas Kimble, Sandra Pufpaf, Janice Fron	Disposition Date: 03/21/2011
	Date Submitted: 03/12/2011	Disposition Status: Filed-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: Revised CPL Med Supp Application	Status of Filing in Domicile: Pending
Project Number: CPL-28300B	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type:
Overall Rate Impact:	Filing Status Changed: 03/21/2011
	State Status Changed: 03/21/2011
Deemer Date:	Created By: Thomas Kimble
Submitted By: Janice Fron	Corresponding Filing Tracking Number:

Filing Description:

RE: STANDARDIZED MEDICARE SUPPLEMENT INSURANCE - 2010 PLANS
Application Form: CPL-28300B-AR

Dear Sir or Madam:

We are filing the above captioned form for your consideration and approval. This form is intended to replace application form CPL-28300-AR, which was previously approved by your Department, to solicit our 2010 Standardized Medicare

SERFF Tracking Number:	*BNLA-127050943*	*State:*	*Arkansas*
Filing Company:	*Colonial Penn Life Insurance Company*	*State Tracking Number:*	*48231*
Company Tracking Number:	*CPL-28300B*		
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.012 Multi-Plan 2010*
Product Name:	*Revised CPL Med Supp Application*		
Project Name/Number:	*Revised CPL Med Supp Application/CPL-28300B*		

Supplement plans. This application will be used in the individual marketplace for person- to-person solicitation by our licensed insurance agents.

The application has been revised with the following:
1. The addition of a tobacco usage question;
2. The addition of underwriting questions;
3. The addition of questions for more clarity in identifying guaranteed issue eligibility;
4. The reordering of questions to help improve the application process time; and
5. The removal of the Authorization section due to its redundancy with our current HIPAA Privacy Notice.

All other information remains unchanged from the previous approved application.

We would like to file Section 1, "Policy Information" and Section 15, "Applicant's Acknowledgment of Notices" as variable so that we can use this application with any future policy forms or notices that may be developed. These two sections contain the only variable information in the application.

This filing contains no unusual or controversial items from normal company or industry standards. We have submitted this form to our home state of Pennsylvania and it is currently pending approval. The Flesch score for the enclosed form is 54.32.

We respectfully request your favorable consideration and approval of this filing. If you have questions on any aspect of this filing, please call me.

Very truly yours,

Janice D. Fron, ALMI, AIRC
Product Approval and Compliance
312-396-7538

Company and Contact

Filing Contact Information

Janice Fron, Filing Project Leader	j.fron@banklife.com
222 Merchandise Mart Plaza - 19th Floor	312-396-7538 [Phone]
Chicago, IL 60654	312-396-5907 [FAX]

Filing Company Information

SERFF Tracking Number:	*BNLA-127050943*	*State:*	*Arkansas*
Filing Company:	*Colonial Penn Life Insurance Company*	*State Tracking Number:*	*48231*
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Colonial Penn Life Insurance Company
Adm. Address: 600 West Chicago Ave
Chicago, IL 60654-2800
(312) 396-6000 ext. [Phone]

CoCode: 62065
Group Code: 233
Group Name:
FEIN Number: 23-1628836

State of Domicile: Pennsylvania
Company Type:
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	ARKANSAS REQUIRES $50.00 PER FORM
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Colonial Penn Life Insurance Company	$50.00	03/12/2011	45522936

SERFF Tracking Number:	*BNLA-127050943*	*State:*	*Arkansas*
Filing Company:	*Colonial Penn Life Insurance Company*	*State Tracking Number:*	*48231*
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Product Name:	*Revised CPL Med Supp Application*		
Project Name/Number:	*Revised CPL Med Supp Application/CPL-28300B*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Filed-Closed	Stephanie Fowler	03/21/2011	03/21/2011

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Stephanie Fowler	03/16/2011	03/16/2011	Janice Fron	03/21/2011	03/21/2011

SERFF Tracking Number:	*BNLA-127050943*	*State:*	*Arkansas*
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Disposition

Disposition Date: 03/21/2011
Implementation Date:
Status: Filed-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*BNLA-127050943*	*State:*	*Arkansas*
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Accepted for Informational Purposes	Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		Yes
Supporting Document	Outline of Coverage		Yes
Form *(revised)*	APPLICATION FOR INSURANCE	Approved	Yes
Form	APPLICATION FOR INSURANCE	Disapproved	No

SERFF Tracking Number:	*BNLA-127050943*	*State:*	*Arkansas*
Filing Company:	*Colonial Penn Life Insurance Company*	*State Tracking Number:*	*48231*
Company Tracking Number:	*CPL-28300B*		
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.012 Multi-Plan 2010*
Product Name:	*Revised CPL Med Supp Application*		
Project Name/Number:	*Revised CPL Med Supp Application/CPL-28300B*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	03/16/2011
Submitted Date	03/16/2011
Respond By Date	04/15/2011

Dear Janice Fron,

This will acknowledge receipt of the captioned filing.

Objection 1

- APPLICATION FOR INSURANCE, CPL-28300B-AR (Form)

Comment: Rule 27, Sec. 11 prohibits discrimination of pricing during Open Enrollment. The Tobacco Use question is an underwriting question and we ask that it be moved to Section 11 or 12 since it is not required to be answered during open Enrollment.

Objection 2

- APPLICATION FOR INSURANCE, CPL-28300B-AR (Form)

Comment: Rule 27, Sec. 18 B requires that the Agent list any other health insurance policies they have sold to the applicant. Please provide a area for this information.

Please feel free to contact me if you have questions.
Sincerely,
Stephanie Fowler

SERFF Tracking Number:	*BNLA-127050943*	*State:*	*Arkansas*
Filing Company:	*Colonial Penn Life Insurance Company*	*State Tracking Number:*	*48231*
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TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.012 Multi-Plan 2010*
Product Name:	*Revised CPL Med Supp Application*		
Project Name/Number:	*Revised CPL Med Supp Application/CPL-28300B*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	03/21/2011
Submitted Date	03/21/2011

Dear Stephanie Fowler,

Comments:
It was nice talking with you on the phone today. Thank you for your comments regarding the filing of application form CPL-28300B-AR.

Response 1

Comments: We have removed the tobacco usage question from Page 1 of the application and moved it to the medical questions on Page 5, #11K for underwritten applications.

Related Objection 1

Applies To:

- APPLICATION FOR INSURANCE, CPL-28300B-AR (Form)

Comment:

Rule 27, Sec. 11 prohibits discrimination of pricing during Open Enrollment. The Tobacco Use question is an underwriting question and we ask that it be moved to Section 11 or 12 since it is not required to be answered during open Enrollment.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
APPLICATION FOR INSURANCE	CPL-28300B-AR		Application/Enrollment Form	Initial		54.320	CPL-28300B-AR.pdf

Previous Version

SERFF Tracking Number:	*BNLA-127050943*	*State:*	*Arkansas*
Filing Company:	*Colonial Penn Life Insurance Company*	*State Tracking Number:*	*48231*
Company Tracking Number:	*CPL-28300B*		
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.012 Multi-Plan 2010*
Product Name:	*Revised CPL Med Supp Application*		
Project Name/Number:	*Revised CPL Med Supp Application/CPL-28300B*		

APPLICATION FOR INSURANCE	*CPL-28300B-AR*	*Application/Enrollment Form*	*Initial*	*54.320*	CPL-28300B-AR.pdf

No Rate/Rule Schedule items changed.

Response 2

Comments: Please see Page 4, Item B. 5. c which provides for this Rule.

Related Objection 1

Applies To:

- APPLICATION FOR INSURANCE, CPL-28300B-AR (Form)

Comment:

Rule 27, Sec. 18 B requires that the Agent list any other health insurance policies they have sold to the applicant. Please provide a area for this information.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
APPLICATION FOR INSURANCE	CPL-28300B-AR		Application/Enrollment Form	Initial		54.320	CPL-28300B-AR.pdf
Previous Version							
APPLICATION FOR INSURANCE	*CPL-28300B-AR*		*Application/Enrollment Form*	*Initial*		*54.320*	CPL-28300B-AR.pdf

No Rate/Rule Schedule items changed.

This should bring our filing into compliance with Arkansas state regulations. We look forward to your approval of our filing. Please let me know if I may be of any further assistance.

SERFF Tracking Number:	*BNLA-127050943*	*State:*	*Arkansas*
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TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.012 Multi-Plan 2010*
Product Name:	*Revised CPL Med Supp Application*		
Project Name/Number:	*Revised CPL Med Supp Application/CPL-28300B*		

Sincerely,

Janice Fron, Sandra Pufpaf, Thomas Kimble

SERFF Tracking Number:	*BNLA-127050943*	*State:*	*Arkansas*
Filing Company:	*Colonial Penn Life Insurance Company*	*State Tracking Number:*	*48231*
Company Tracking Number:	*CPL-28300B*		
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.012 Multi-Plan 2010*
Product Name:	*Revised CPL Med Supp Application*		
Project Name/Number:	*Revised CPL Med Supp Application/CPL-28300B*		

Form Schedule

Lead Form Number: CPL-28300B-AR

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 03/21/2011	CPL-28300B-AR	Application/ Enrollment Form	APPLICATION FOR INSURANCE	Initial		54.320	CPL-28300B-AR.pdf

APPLICATION FOR INSURANCE TO

Colonial Penn Life Insurance Company ("The Company")
Home Office: 399 Market Street • Philadelphia, PA 19181
Administrative Office: 11825 North Pennsylvania Street • Carmel, IN 46032

1. Policy Information **(PLEASE CLEARLY PRINT ALL INFORMATION)**

I apply for coverage on Form CPL-GR-A80:

☐ PLAN A ☐ PLAN B ☐ PLAN F ☐ PLAN HIGH DEDUCTIBLE F

☐ PLAN G ☐ PLAN K ☐ PLAN L ☐ PLAN M ☐ PLAN N ☐ OTHER _____

2. Personal Information of Applicant

First Name M.I. Last Name Suffix

Gender: ☐ M ☐ F Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Date of Birth (mm-dd-yyyy) Age

Medicare ID Number -

Social Security Number
(Show only if no Medicare ID Number)

Railroad Retiree Number
(Please provide if applicable)

3. Contact Information

A. Home Address

Street Address

City/Town State Zip Code -

Home Phone - - Work Phone - -

E-mail Address

B. Billing Address (Complete only if different than home address).

Street Address

City/Town State Zip Code -

4. Association/Organization Verification (Complete this section only if applicable).

The Applicant is an employee/member in good standing of:

Association/Organization Account Number

5. New Coverage

A. I am in an **Open Enrollment or Special Enrollment Period**. . . . . ☐ Yes ☐ No
If "Yes," **DO NOT ANSWER THE MEDICAL QUESTIONS** on Page 5.

B. I am eligible for **Guaranteed Issue coverage** because my coverage below is terminating or has terminated within the last 63 days . . . . . ☐ Yes ☐ No

If "Yes," please indicate if ☐ **Voluntary or** ☐ **Involuntary** termination, the **type of coverage** that's terminating and provide the **coverage end date** below. Also, **DO NOT ANSWER THE MEDICAL QUESTIONS** on Page 5.

☐ Employee Welfare Benefit Plan (Group) ☐ Medicare Advantage ☐ Private Fee For Service (PFFS)

☐ Medicare Select Plan, Medicare Risk or Cost Plan, or a Medicare HMO Plan ☐ Medicare Supplement Plan

☐ Other Guaranteed Issue **Special Enrollment Period** or circumstance (Please provide details in #16 Remarks)

Coverage End Date: ____ - ____ - 20 ____ ☐ **Required Termination Letter attached.**

C. Please answer the following questions for **Medicare Advantage terminations only:**

1. I have voluntarily ended my Medicare Advantage Plan during the 12 months Trial Period . . . . . ☐ Yes ☐ No
   If "Yes," please provide the date the Medicare Advantage plan started: ____ - ____ - 20 ____
   ☐ **Required Confirmation Letter of Disenrollment from Medicare Advantage plan attached.**
2. Prior to my enrollment in Medicare Advantage I was insured under a Medicare Supplement . . . . ☐ Yes ☐ No
   If "Yes," please provide the prior Medicare Supplement plan name (A through N) _____.

D. **Requested Issue Date** ____ - ____ - 20 ____

6. Post-Issue

☐ **Exchange** ☐ **Reinstatement** ☐ **Other** _____

Existing Policy Number _____ to be exchanged or reinstated.

List any other existing policy number(s) to be ended or changed:

_____		_____		_____	
☐ End	☐ Change	☐ End	☐ Change	☐ End	☐ Change

Describe any change(s): _____

7. Qualifying Information

Questions 7A. through 7C. must always be answered.	**YES**	**NO**
A. Are you insured under Part A and Part B of Medicare?	☐	☐
B. Is the state paying your Medicare Part B premium?	☐	☐
If "YES" under which program? (for example, Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), etc.) _____		
C. Do you receive federal, state or local government financial assistance in any form, such as Supplemental Security Income?	☐	☐
If "YES" what form? _____		

8. Other Health Coverage

A. Statements to Proposed Insured:

1. You do not need more than one Medicare supplement policy.
2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
3. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
4. If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility.

8. Other Health Coverage (Continued)

A. Statements to Proposed Insured:

5. If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days after losing your employer or union-based group health plan.

6. Counseling services may be available in this state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

B. Questions

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application.

PLEASE ANSWER ALL QUESTIONS. (Please mark YES or NO below with an "X", as applicable)

To the best of your knowledge: **YES** **NO**

1. (a) Did you turn age 65 in the last 6 months? . . . . . ☐ ☐

(b) Did you enroll in Medicare Part B in the last 6 months? . . . . . ☐ ☐

(c) If "Yes," what is the effective date? . . . . . ___ - ___ - 20___ Date (mm-dd-yy)

YES **NO**

2. Are you covered for medical assistance through the state Medicaid program? . . . . . ☐ ☐

NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.

If "Yes," **YES** **NO**

(a) Will Medicaid pay your premiums for this Medicare supplement policy? . . . . . ☐ ☐

(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? . . . . . ☐ ☐

3. (a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (e.g. Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates. If you are still covered under this plan, leave "End" blank.

Start: ___ - ___ - 20___ Date (mm-dd-yy)

End: ___ - ___ - 20___ Date (mm-dd-yy)

YES **NO**

(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? . . . . . ☐ ☐

(c) Was this your first time in this type of Medicare plan? . . . . . ☐ ☐

(d) Did you drop a Medicare supplement policy to enroll in the Medicare plan? . . . . . ☐ ☐

4. (a) Do you have another Medicare supplement policy in force? . . . . . ☐ ☐

(b) If so, with what company and what plan do you have?

Company: _____

Plan: _____

YES **NO**

(c) If so, do you intend to replace your current Medicare supplement policy with this policy? ☐ ☐

B. Questions (Continued) **YES** **NO**

5. Have you had coverage under any other health insurance within the past 63 days? . . . . . ☐ ☐
(For example, an employer, union or individual plan)
(a) If so, with what Company and what kind of policy?

Company: _____

Policy: _____

(b) What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave "End" blank.)

Start: ___ - ___ - 20 ___ Date (mm-dd-yy)

End: ___ - ___ - 20 ___ Date (mm-dd-yy)

C. The agent shall list any other health insurance coverage they have sold to the applicant.

(a) List policies sold which are still in force. _____ _____

(b) List policies sold in the past five (5) years which are no longer in force. _____ _____

9. Replacement of Other Health Coverage

A. Will any existing ☐ Accident or Sickness, ☐ Specified Disease, ☐ Hospital Indemnity, ☐ Accident/Travel Accident or ☐ Nursing Home, Long Term Care, Short Term Care or Home Health Care Plan be replaced or changed if this proposed policy is issued? If "Yes", give details below: **YES** ☐ **NO** ☐

Company	Policy Number	End Date (mm-dd-yy)
		___ - ___ - 20 ___
		___ - ___ - 20 ___
		___ - ___ - 20 ___
		___ - ___ - 20 ___

10. Additional Medicare Supplement/Medicare Advantage Replacement Information

A. If you are replacing a Medicare Supplement policy or a Medicare Advantage plan, please indicate the reason below:

☐ Additional benefits
☐ No change in benefits, but lower premiums
☐ Fewer benefits and lower premiums
☐ My plan has outpatient prescription drug coverage and I am enrolling in Part D
☐ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment. _____
☐ Other, please specify _____

B. If you are replacing a current Medicare Supplement plan, what plan is being replaced?

☐ Plan A ☐ Plan B ☐ Plan C ☐ Plan D ☐ Plan E ☐ Plan F ☐ Plan F with high deductible
☐ Plan G ☐ Plan J ☐ Plan K ☐ Plan L ☐ Plan M ☐ Plan N

REMINDER: If this application is intended to replace existing Medicare Supplement or Medicare Advantage coverage, please remember to **also complete Form CPL-4043-SUP, "Notice To Applicant Regarding Replacement Of Medicare Supplement Insurance Or Medicare Advantage."**

DO NOT ANSWER MEDICAL QUESTIONS #11 AND #12 IF YOU ARE IN OPEN ENROLLMENT OR A SPECIAL ENROLLMENT PERIOD (SEP) THAT QUALIFIES FOR GUARANTEED ISSUE. CONTINUE ON THE NEXT PAGE WITH #13.

11. Medical Questions 11A. through 11J.

A. Please list your height and weight: ___ ' ___ " Height (Feet and Inches) ___ Weight (Pounds)

		YES	NO
B.	Are you now confined in a hospital or nursing home, or, within the past 60 days, have you been advised by a doctor to seek medical care or treatment in a hospital or in a nursing home?	☐	☐
C.	Are you bedridden?	☐	☐
D.	Do you require the use of a wheelchair? If "Yes," please provide details in #16 Remarks	☐	☐
E.	Are you receiving kidney dialysis?	☐	☐
F.	Do you have diabetes? If "Yes," please indicate below the type(s) of medication(s) that you use: ☐ Insulin ☐ Pills Please provide the Rx name(s): _____ ☐ Other form of treatment _____	☐	☐
G.	Have you, due to mental or physical disability, authorized any person or institution to legally act on your behalf and take over your personal transactions?	☐	☐
H.	In the past 12 months, have you been advised to have surgery but it has not yet been done?	☐	☐
I.	In the past 12 months, have you been hospitalized three or more times?	☐	☐
J.	Do you routinely visit the same medical provider more than monthly for medical advice or treatment? If "Yes," please provide details in #16 Remarks.	☐	☐
K.	Have you used tobacco in any form within the past 12 months ?	☐	☐

12. Medical Questions 12A. 1-13 and 12B. 1-3

A. Do you now have any of the following conditions or have you received medical advice or treatment for the following conditions **within the past 24 months**:

		YES	NO
1.	Any form of Chronic Lung Disease including Chronic Obstructive Pulmonary Disease (COPD), Emphysema or Chronic Bronchitis?	☐	☐
2.	Any form of Chronic Liver Disease including Hepatitis B or C or Cirrhosis?	☐	☐
3.	Stroke?	☐	☐
4.	Angina Pectoris, Heart Attack, Congestive Heart Failure, Valvular Heart Disease, Aneurysm, Arteriosclerosis or Atherosclerosis, Atrial Fibrillation, Cardiomyopathy, Coronary Artery Disease, or Peripheral Vascular Disease?	☐	☐
5.	Alzheimer's Disease, memory loss or impairment, dementia or cognitive impairment?	☐	☐
6.	Parkinson's Disease?	☐	☐
7.	Multiple Sclerosis?	☐	☐
8.	Chronic Kidney Disease?	☐	☐
9.	Any form of Arthritis or Degenerative Bone Disease causing crippling, fractures, limitation of motion, or requiring past or future joint replacement?	☐	☐
10.	Systemic Lupus Erythematosus?	☐	☐
11.	AIDS or HIV positive?	☐	☐
12.	Bone Marrow or Organ Transplant?	☐	☐
13.	Substance Abuse?	☐	☐

B. Do you now have any of the following conditions or have you received medical advice or treatment for the following conditions **within the past 36 months**:

		YES	NO
1.	Cancer (other than skin cancer)?	☐	☐
2.	Leukemia or Lymphoma?	☐	☐
3.	Melanoma?	☐	☐

13. Premium Payment Service Plan (PPSP) **YES** **NO**

I want my policy to be paid each month by Electronic Funds Transfer (EFT) from my bank account . . . . . ☐ ☐
If "Yes," please complete **ALL FIELDS** below.

Note: To help ensure encoding accuracy of bank information, **please include a sample check marked "VOID."**

Bank Routing/Transit Identification Numbers (The first set of numbers in the lower left hand bottom of check - 9 digits)

☐ Checking or ☐ Savings Account Number

Account Name

Bank Name

City/Town

State

Zip Code -

Please charge my account on the ____ day of the month.

I also want these policy numbers billed on the PPSP plan (EFT):

14. Acknowledgments

THE APPLICANT REPRESENTS AND AGREES AS FOLLOWS:

A. I have read, or had read to me, the completed application and realize that any false statements or misrepresentation in this application may result in loss of coverage under the policy.

B. No agent is authorized to waive or modify any terms of this application.

C. No agent, medical examiner or other person is authorized to accept risks, pass upon insurability, make or modify contracts or waive any of the Company's rights or requirements.

D. If premium was paid with this application, I have read the receipt for same and fully understand the conditions and limitations stated in the receipt, and that no agent can waive or change such conditions and limitations.

E. Any insurance issued as a result of this application will either: (i) not take effect for insurance unless and until the full first premium is paid and the policy is delivered during my lifetime and while I am in the condition of health set forth in this application; or (ii) take effect as may be specified in the receipt, if any, completed with this application.

F. For an exchange, the new coverage will be treated as a renewal of any current coverage.

15. Applicant's Acknowledgment of Notices

I have received and acknowledge receipt of the following:

- "Guide to Health Insurance for People with Medicare"
- Applicable Outline of Coverage
- Notice Regarding Replacement, if applicable
- Conditional Receipt, if applicable
- Privacy Notice
- Authorization for Underwriting Purposes (Note: Does **not** apply to Open Enrollment or Guaranteed Issue)

16. Remarks:

17. Third Party Countersignature

Note: If the Applicant is age 85 or older, a third party presence is required and the following statement completed by a trusted relative, friend or financial advisor who was present at the time of this sale.

Third Party First Name _____ M.I. _____ Last Name _____ Suffix _____

Relationship to Applicant _____ _____ number of years I have known the Applicant.

Home Address _____

City/Town _____ State _____ Zip Code _____ - _____

_____ - _____ - _____
Home Phone

Signature of Third Party X _____

18. Signatures

I certify that the statements contained in the application are complete, true and correct. If my answers on this application are incorrect or untrue, the Company may have the right to deny benefits or rescind my coverage.

Dated at City/Town _____ State _____ Zip Code _____ - _____

This _____ Day of _____ 20 _____

Signature of Applicant X _____

I have witnessed the signature of the Applicant. I certify that I asked all the applicable questions and truly and accurately recorded the answers contained herein. I certify that the Applicant has read the completed application or had it read to him or her. To the best of my knowledge and belief, except as may be stated by the responses to Questions 9 and 10, the insurance applied for is not or is not likely to replace or change any existing policy(ies) or contract(s).

Signature of Licensed Resident Agent X _____ Agent No. _____ _____ %

Branch Office Number _____

Signature of Licensed Resident Agent X _____ Agent No. _____ _____ %

Branch Office Number _____

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss of benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

PLEASE MAKE ALL CHECKS PAYABLE ONLY TO COLONIAL PENN LIFE INSURANCE COMPANY

SERFF Tracking Number:	*BNLA-127050943*	*State:*	*Arkansas*
Filing Company:	*Colonial Penn Life Insurance Company*	*State Tracking Number:*	*48231*
Company Tracking Number:	*CPL-28300B*		
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.012 Multi-Plan 2010*
Product Name:	*Revised CPL Med Supp Application*		
Project Name/Number:	*Revised CPL Med Supp Application/CPL-28300B*		

Supporting Document Schedules

		Item Status:	**Status Date:**
Satisfied - Item:	Flesch Certification	Accepted for Informational Purposes	03/21/2011

Comments:

Attachment:

Flesch Cert.pdf

		Item Status:	**Status Date:**
Bypassed - Item:	Application		
Bypass Reason:	Not applicable.		
Comments:			

		Item Status:	**Status Date:**
Bypassed - Item:	Health - Actuarial Justification		
Bypass Reason:	Not applicable to this filing.		
Comments:			

		Item Status:	**Status Date:**
Bypassed - Item:	Outline of Coverage		
Bypass Reason:	Not applicable to this filing.		
Comments:			

STATE OF ARKANSAS

Certification

This is to certify that the attached Application for Insurance
(Name of Form)
Form No. CPL-28300B-AR has achieved a Flesch Reading Ease Score of 54.32 and complies with the requirements of Ark. Stat. Ann. 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

COLONIAL PENN LIFE INSURANCE COMPANY

Officer of Company

Senior Director and Assistant Secretary
Title

March 12, 2011
Date